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Citation for published version:

Stenhouse, R 2013, 'Hearing Voices: Re/Presenting the Findings of Narrative Research into Patient Experience as Poems', *Journal of Psychiatric and Mental Health Nursing*. <https://doi.org/10.1111/jpm.12094>

Digital Object Identifier (DOI):

[10.1111/jpm.12094](https://doi.org/10.1111/jpm.12094)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Published In:

Journal of Psychiatric and Mental Health Nursing

Publisher Rights Statement:

© Stenhouse, R. (2013). Hearing Voices: Re/Presenting the Findings of Narrative Research into Patient Experience as Poems. *Journal of Psychiatric and Mental Health Nursing*. 10.1111/jpm.12094

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`Hearing voices: re/presenting the findings of narrative research into patient experience as poems

Abstract

Aims and objectives: The study aimed to understand the experience of being a patient on an acute psychiatric inpatient ward. A further aim was to open up spaces for the voices of participants to be heard.

Background: Contemporary Government policy places patient experience at the centre of healthcare policy and service development. Despite this, those who occupy marginalised discourses struggle to be heard within the dominant discourse of healthcare.

Research design: A qualitative approach was used, and narrative was conceptualised as representing experience. Sociolinguistic theories informed the development of the analytic framework treating meaning as contextual and arising from both content and structure of narratives. Concepts of representation, voice and authorship were problematized.

Method: 13 people who had been inpatients on an acute psychiatric inpatient ward participated. Narrative data were gathered using unstructured interviews. The data were analysed holistically using a method which attended to both the structure and content of the narrative. The product of these holistic narratives was the development of a poem representing each participant's experience. This paper focuses on the development of these poems as a method of decentring the authorial voice and opening up spaces for the voices of the participants to be heard.

KEY WORDS: PATIENT PERSPECTIVES; RESEARCH DISSEMINATION; MENTAL HEALTH; NARRATIVE; QUALITATIVE APPROACHES; DISCOURSE; POWER

ACCESSIBLE SUMMARY:

- Research into the patient's perspective on their care is being given increasing importance within health and nurse education policy, predicated upon the idea that the findings represent the patient experience.
- Researchers have power to silence the voices of research participants through the process of authorship.
- Exploring the arts as a means of presenting findings offers the opportunity to problematize issues of power and authorship and examine ways of decentring the researcher's voice.
- Re/presenting participants' experiences in poetic form allows the researcher to present the essence of that experience in a holistic form.
- Retaining some fidelity to the structure and language of the original narrative allows readers to connect with a range of clues about the participant's experience.
- Re/presentation of patient experience in poetic form encourages readers to engage with that experience as they have to actively interpret the meaning of the poem.
- Researchers interested in examining and conveying the experience of others should be encouraged to problematize issues of authorship and consider the impact of their authority on the re/presentation of the experience of the other.

INTRODUCTION

Contemporary UK health care policy places the patient at the centre of service and policy development (Scottish Government 2010; Department of Health 2004, 2012). The rationale for such inclusion is the development of safe, effective, patient centred services (Scottish Government 2010; Francis 2013), and education that produces nurses who are caring and compassionate (NMC 2010; Willis 2012).

The extent to which the service user's voice is heard through the products of research is impacted by issues of power within the research relationship. Qualitative narrative research into patients' experience offers the opportunity for their voices to be heard within the discourses of healthcare. However, writing research has the potential to reproduce the dominant power structures of society (Bertram 1998; Lather 1991; Richardson 1990; Standing 1998; Alldred 1998). This paper describes how poetic re/presentations of participants' experiences were developed in an attempt to address this issue.

Narrative representation of experience

Laing (1967) argues for the "*invisibility*" of experience. What we refer to as 'experience' is therefore a representation (Riessman 1993; Polkinghorne 1988; Frank 1995; Gee 1991). Narrative is understood as one of the primary ways in which human beings represent experience (Gee 1985; Riessman 1993; Frank 1995). Some argue that as

we narrate our experiences we are simultaneously creating our reality and expressing it through our linguistic choices (Gee 2005; Jakobson 2006; Bruner 1991).

How we use language, the grammatical choices we make when forming narratives, therefore, allows us to create a version of reality, our experience, from a particular perspective (Gee 2005, 1990). Through their narratives we can see how people make sense of the events in their lives, how they attribute causality, and the connections that they make between disparate events (Werner *et al* 2004; Gale *et al* 2003; Rosenwald & Ochberg 1992).

Discourse and power

Such narrative construction occurs in the context of social discourse (Gee 1990, 2005; Gubrium & Holstein 1995; Berger & Luckman 1966). Gee (2005) defines discourse as the resources – values and norms - that enable people to occupy, and be recognised as occupying, particular subject identities. Thus, membership of particular discourses provides individuals with particular language resources to enable them to narrate their experiences (Gee 2005).

Discourse as carrier of norms and values is ideological and therefore constitutive of the power structures of society (Gee 1990; Jaworski & Coupland 2006). Harding (1998) argues that all human beings occupy positions at the juncture of hierarchical social locations, such as gender, class and race. These positions are linked to the distribution of social goods making some positions more acceptable or desirable than others (Davies

1992). Such positioning leads to the marginalisation of viewpoints, whilst others who occupy more powerful positions dominate.

Within the wider discourse of psychiatry and mental health care, the service user occupies a marginalised discourse. As a mental health nurse researcher I occupy dominant positions within academic and health discourses in relation to the participants. Such positioning provides the opportunity to enable the voices of those in the marginalised discourse to be heard by those occupying the dominant discourses; or silenced through the power differential of the research relationship.

Writing participants' lives

“When we write social science, we are using our authority and privileges to tell about the people we study. No matter how we stage the text, we – as authors – are doing the staging. As we speak about the people we study, we also speak for them. As we inscribe their lives, we bestow meaning and promulgate values.”

Richardson 1990: 12

The process of writing is embedded in power structures, with the ability to reproduce or disturb dominant power relations (Bertram 1998; Lather 1991; Richardson 1990; Standing 1998; Alldred 1998). Authorial representation of participant voices is thus a political activity (Rothman 1996). Traditional research writing draws its authority from adopting the objective stance of the view from nowhere (Haraway 1991). Such

objectification removes the narrator from the text (Richardson 1990), and cleaned up quotations silence participants' voices (Standing 1998).

Bertram (1998) identifies that many feminist authors adopt writing practices that attempt to circumvent this authority effect. Lieblich (2006) refers to what she terms the '*performance turn*' (61), the consequence of a rise in post-modernist epistemologies, and the ensuing contestation of issues pertaining to "*writing and representation in our academic field*" (Lieblich 2006: 61). This shift has legitimated the adoption of a diverse range of presentational media by researchers, including the use of plays (Ellis & Bochner 1992; Lieblich 2006); poetry (Hill 2005; Kendall & Murray 2005; Richardson 1992; Clarke *et al*, 2005; Kidd & Tusaie 2004; Chapman 2007; Holmes & Gregory 1998); and short stories (Parry 2004, 2006; Shingler 2007; Shelton & Johnston 2006).

These different methods of representation disrupt the usual writing practices of the Academy (Bertram 1998; Lather 1991). They create distance between the data and the world, celebrating its interpreted nature, openly acknowledging the data as representation (Lather 1991; Oikarinen-Jabai 2003). Audiences are invited to engage with these representations, interpreting their meaning (Barone & Eisner 2012). Such engagement facilitates aesthetic knowledge development through the audience's empathic response to the other's experience (Holmes & Gregory 1998; Hunter 2002; Kidd & Tusaie 2004; Kendall & Murray 2005; Barone & Eisner 2012), a process relevant to nursing with its relationship focus (Hunter 2002).

However, despite the use of such techniques, the written text remains the writer's responsibility (Freshwater 2007; Richardson 1990). In this paper I discuss some of the mechanisms I used to deal with this authorial power when re/presenting the experiences of research participants.

THE STUDY

Aims

The aim of the study was to gain an understanding of what it is like to be a patient on an acute psychiatric inpatient ward. A further aim of the study was to offer a space for the voices of people who had been patients on an acute psychiatric ward to be heard.

Methodology

A qualitative design was chosen to investigate the main research question: *What is it like to be a patient on an acute psychiatric inpatient ward?* The study sought to understand the experience of being a patient; experience was understood as represented through narrative (Riessman 1991, 1993; Frank 1995; Gee 1985) in the context of social discourse (Gee 1990, 2005).

Unstructured interviews allowed participants to structure their narratives how they chose, drawing on their own language resources, producing accounts that were close representations of their experience (Thomas & Pollio 2002). The researcher adopted the stance of active listener, using probing questions and reflective statements arising from the participant's narratives to increase the depth of the data (Rosenthal 2003).

Narrative meaning was conceptualized as contextually dependent (Gee 1990, 2005; Werth 1999; Shotter 1993) leading to holistic analysis (Lieblich *et al* 1998). Gee (1990) and Shotter (1993) argue that the manner in which a speaker makes a point is instructive of its meaning; emphases and word order indicate what the speaker wants the hearer to note as important (Shotter 1993; Gee 1990, 1991). An analytic framework based on Gee's (1991) identification of narrative structure was developed.

Participants

Thirteen participants (6 male, 7 female) aged 18–65 years with a variety of diagnoses and numbers of hospital admissions took part in the study. Participants were recruited from an acute ward in a large psychiatric hospital serving an urban–rural area in Scotland between May and August 2006.

Nursing staff introduced the researcher to potential candidates. Patients were eligible for inclusion if they had the capacity to give informed consent; did not pose a risk of violence to the researcher; were not being detained on a criminal section of the Mental Health (Care and Treatment) (Scotland) Act 2003; and had been in the ward one week or more.

Patients who were agreeable met the researcher to discuss the research and receive written information. Verbal consent was gained from participants whilst they were on the ward. Participation in the study was confidential.

The study was discussed with 16 patients; 15 agreed to participate. Two were then unavailable for interview and did not respond to further communication, so were excluded from the study.

Data collection

Unstructured interviews, beginning with a broad statement asking participants to tell their story about being on the acute ward, were carried out 2 weeks post discharge.

Following the first interview the transcripts were read and the main themes of the participant's narrative drawn out and summarized. This summary was sent to the participant and formed the basis of a second interview; providing the opportunity for clarification of misunderstandings and deeper exploration of the issues arising from the first interview (Hollway & Jefferson 2000).

To facilitate in-depth accounts of their experience, data collection took place away from the hospital environment in a setting of the participant's choosing (Green & Hart 1999); all chose to be interviewed at home. Safety issues were considered as part of the ethical review process. Interviews lasted from 45 minutes to 2 hours. All interviews were digitally recorded.

Ethics

Ethical permission was granted through the NHS ethical review system. Participants were given written and verbal information about the study. Participation was voluntary and confidential. Written consent was gained. Anonymity was maintained through assignment of pseudonyms. Consent was explicitly sought regarding use of anonymised quotations from data. Data were treated in accordance with Data Protection legislation.

Data analysis

On completion of the second interviews, all data were transcribed verbatim, noting pauses and other breaks as well as non-lexical utterances. The data set for each participant was conceptualised as a big narrative constituted of many intertwining small narratives. These small narratives formed the unit of analysis. They were identified within the interview transcripts using Gee's (1991) ideas that narratives are prefaced with dysfluencies caused by the narrator organising their thoughts before commencing the narrative. Each small narrative was then re-transcribed following Gee's (1991) theories to make visible the narrative structures; cohesive devices, emphases, pauses, organisation of ideas into lines and stanzas, as these are argued to guide the interpretation of meaning. Line-by-line analysis focussed on how the narrator had used these structures to develop meaning within the narrative. Analysis then focussed on how these small narratives related to create the bigger whole; the participant's experience. It is these holistic analyses of participants' experiences that were the basis of the poems.

Development of the poems

Language and imagery

The poems were developed to reflect both the ‘how’ of the narratives as well as the ‘what’. I remained true to the form of speech, and language, used by the participant, and included, verbatim, phrases and images that were central features of the narratives.

Some participants repeatedly used particular images or phrases. For example, Peter constantly referred to the nursing notes as his “*record*”, repeating phrases such as “*it won’t look good on your record*”. Such phrases were central to the interpretation of Peter’s narrative, and were retained as a form of refrain within the poem representing his experience (see box 1). Repetition of these phrases in the poems, as they had been repeated in the narratives, was intended to make this part of the narrative structure visible.

BOX 1: Peter’s story

I knew I was ill,
Kept going to the doctor,
 asking for referral to hospital;
I wasn’t ill enough she said.

I could feel my illness taking hold,
Losing my sense of what was real,
 feeling threatened;
I needed to get into hospital.

I had a plan to get me in,
 vandalise some property.
Somebody will phone the police,
 they will take me to hospital.

I’ve finally made it to hospital,
Now I’m safe.

The nurses make their observations,
 Judging you as a person,

Write these on your record for the consultant,
so he can make his decisions.

So always make them feel that they're in charge,
even though they're getting their orders from above.

If you are nice to the nurses, they will be nice to you.
You need to treat them with respect,
be a good patient,
Because it all goes on your record.

And don't walk round all scruffy,
unwashed and unshaven,
That shows a bad attitude;
It will probably go in your record

Make the staff aware that you are trying to help yourself,
let them know you want to get out.
Don't be lying on your bed, or smoking all day,
because it won't look good on your record

If you knock on the door, and the staff are busy,
let them know where you will be.
Don't disappear off, it'll only annoy them,
and that won't look good on your record.

And when you are aware that the nurses observe you,
it's hard to be yourself.
I hid my sense of humour;
Didn't want it to go on my record.

When you're on the ward you are a 'mentally ill' patient,
with no credibility as a competent agent,
Always feeling that you need evidence
to back up what you say.

But when you get out,
get your discharge papers,
Then you can become, once more,
a fully paid up member of society.

Others offered evaluations of how they felt at particular points during their experience
“*hellish*” “*ghastly*” (Amanda), “*conned*” “*neglected*” (Jill). Jill’s narratives were
punctuated by emotional references which formed key reference points (see box 2).

BOX 2: Jill’s story

Shocked:
“Hello, I’m your admitting doctor”
Somebody’s conned me,
I thought I was just going to be assessed;
“You don’t have to stay if you don’t want to.”

Desperate,
I agreed to stay.
If I went home, and the next day I had to phone my GP,
And he’d set all this up for me,
That wouldn’t be very fair.

Tearful:
“We’ll give you some lorazepam to settle you down”
Fell asleep.
Woken hours later;
“We forgot about you.”

Frightened,
I didn’t know the ward routine
Or where anything was.
Nothing explained,
Not shown around the ward.

Neglected,
I lay on my bed and cried.
Nobody came.
I felt conned,
Neglected.

Expected
People would be helping me,
Counselling me.
Nobody came near me,

I just lay on my bed and cried.

Frightened,
I didn't know who I was in with,
Or how to react to the other patients;
Do I look at them?
Better not ignore them.

Crying,
I lay behind the screens
Waiting for someone, but
Nobody came.
I didn't even know their names.

Antisocial?
“We don't do antisocial, you have to come find us”
How could I when I'd been ignored, and
Nobody introduced themselves?
I couldn't approach them.

I can't stay here, they're doing nothing for me

Empathy,
One nurse came, and confided in me
That she could see I was struggling.
Relieved to have someone recognise my plight,
And acknowledge my feelings.

Busy;
What do the nurses do?
We were all self caring,
Showered, dressed and fed ourselves;
So why did they not have time for us?

Friends;
A patient took me under her wing,
Introduced me to a couple of others.
Chatting and eating together,
My saving grace.

Vulnerable,
My friends were on pass for the day,
I was stalked by a female patient.
Eating my lunch, she moved to my table,
Missing my face as her fist shot toward me.

Hysterical,
I retreated to the safety of my room.
The staff said they were watching,
Would keep an eye,
But I had to understand she was ill.

I can't stay in this place any longer

Institutionalised,
Queuing for medication,
Determined I was not going to do that.
I didn't want to be difficult,
So I joined the queue.

Escape,
The CPN said I'd been discharged
Earlier than he would expect.
I had planned my discharge,
And suggested a support package

Because I couldn't stay there any longer

Angry,
I feel really cheated,
Told that I would get help.
That's why I agreed to stay,
But all it was, was time out.

Stigma.
Now it's in my medical notes,
That I've been in a psychiatric hospital.
I could deal with that, if I thought they had helped,
But my expectation was not fulfilled.

Representing the structure of participants' narratives in the poems

Gee (1991) contends that narrative structure is central to the development of meaning. When constructing the poems, their form, presentation on the page, the length and rhythm of the stanzas, and the inclusion of a refrain, was an attempt to reflect how participants

told their stories, and how they positioned themselves within these. For instance, when interviewing John his narratives felt rehearsed, as if they had been told to many audiences over the years, and in fact the same stories were repeated almost verbatim during the second interview. Whilst writing his poem one of the later stanzas had a rhyming structure. This rhyming stanza felt different when read, it kept the reader at a distance, just as John's highly rehearsed stories had kept me at a distance during interviews. John's poem was then rewritten with a formal rhyming meter as this seemed to represent how he had told his story (see box 3).

BOX 3: John's story

I was only in a short time,
the doctor said he'd not keep me long,
Not like the last time, when
the admission went on and on.

It's the doctor who decides, you see,
if you are getting out,
That's why you should be polite to him,
never scream and shout.

Because if you lose your temper,
or challenge what he says,
He will make your time more awkward,
or extend how long you stay.

They say they can leave any time,
that simply isn't true,
If staff think you're not ready,
they will section you.

But there's some who're on a section,
who take full advantage of the fact,
They can't be put out for substance use,
while under the Mental Health Act.

The inmates sit around smoking,

there's little else to do,
Telling nonsense stories
that can't possibly be true.

And their stories irritated me,
but once I felt safe enough,
Instead of getting cross at them,
I knew that I could laugh.

The boredom leads to arguments,
at mealtimes in particular.
Intimidated, leaving your meal on the table,
you retreat to somewhere safer.

And if one of them hits the other,
they're straight down on the floor,
The nurses restrain them, move them up
to the ward where they lock the door.

And when you speak to the nurses,
they ask you silly questions
Like, "what was the celtic score last week?"
and "what did you have for breakfast?"

And I know that they're just testing my brain,
testing the state of my memory,
So I answer them with sarcasm,
because they know the answers already.

I never want to go back in,
I can't stand all the nonsense
Of the other patients' stories, and
the nurses' silly questions.

Dissonance characterized Cathy's story as she tried to assimilate her negative experiences of being a patient on the ward with the discourse that nurses are good, caring, and have too much paperwork. Throughout her narratives, Cathy repaired criticisms with praise for the system, or statements indicating that she understood the difficult position of the

nurses constrained by the hospital and psychiatric systems. These statements were juxtaposed in her poem to make this dissonance visible (see box 4).

BOX 4: Cathy's story

I've had experience before, of being on acute wards
in other hospitals.

This was an inviting place,
it made you feel at ease.

You had to wait for the doctor to come,
I understood that from being in other hospitals.
Some of the people that came in for the first time, didn't understand,
they became very impatient.

I thought the nursing staff were fine,
I thought they did their job well,
I thought, like on previous occasions,
they have a terrible amount of paperwork.

The method of dispensing medication was the same:
queue up outside a room.
I had to get a lot of medication, so I took it in a big handful,
some people have to pick it out one pill at a time.

And the place was scrupulously clean.

I don't like bothering senior staff for a menial task
but I couldn't tell who anyone was,
cos they wear badges on the waist band
But I cannae bend down that far to see,
it's one of the only criticisms I have.

I felt the food was very good.

Two boys went missing from the ward,
Allowed back in that night,
drunk,
playing loud music in the day room.

And it transpires a female patient had done a similar thing,
but caused no problem,
And she was put out.

Everybody left the room bar me,
I wouldn't be intimidated,
I hate bullies.
So I got into an argument with them.

I certainly felt intimidated,
I wanted to leave the ward
That's the only complaint I've got,
it was bad judgement of the staff.

Again, I know the system:
If they're under a section, you cannae put them out the ward,
but they certainly have facilities they can put them into up there.

There should be a patients' charter on the wall
to protect everyone's human rights.
I should have the right as a patient to feel safe,
protected against people like that coming in.

I have nothing to complain about,
It was spotlessly clean.

Inside the goldfish bowl,
you watch the world go by outside,
The time the postman comes;
The time the pharmacy van delivers;
The dinner van arrives - it's lunch,
Punctuating the day's routine.

I thought they'd have taken you for walks,
taken us out as a group.
I suppose they might be frightened you run away.

The days run into one another,
connection with the outside lost.
As you get better you say, "I wonder how many letters I've got?"
Missing friends,
Missing the Bingo,
Beginning to reconnect with my life out there.

But no, I cannae complain, honestly,
there was no sister kratchet,
she wasnae there.

The staff were available
but they were always writing up files.
I don't think any of them are work shy,

other than staying in the office.

Obviously, when they're doing a synopsis of what I've said,
multiply it by 30,
It takes a lot of time.

A wee girl came in and had shock treatment;
I could tell she was getting the shock treatment, I knew,
but probably everybody else on the ward didnae notice;
that thing in the back of her hand.

There's quite a camaraderie with the other patients,
those with similar illness congregate,
But there's always one that advises the wee ones that 's coming in,
"I'll tell you what to do to get ..."
But it's interfering with people's medication;
I've noticed this in the other hospitals too.

I put off going into hospital,
"I cannae put up with the shouting and bawling that goes on"
The disturbance created by a wee core of patients;
I've seen it in other hospitals too

I don't think there was anything they could have done,
To make you feel more comfortable.

DISCUSSION

Riessman (1993) argues that there are many levels at which representation occurs within narrative research; the final one being the representation of the participants' narratives to the audience who in turn, interpret these. However, representation is not understood simply as holding a mirror to reality, but a political process that occurs within the power structures of the researcher-researched relationship (for which I use the term 're/present' to indicate the interpretive nature of this). When researching the experience of people who use mental health services, the researcher risks reproducing the dominant power relation between the patient and the psychiatric system. Recognition of the researcher

authority implicit within traditional research writing led to the exploration of alternative modes of re/presentation to decentre the authorial voice and the development of poems to re/present the experience of the research participants.

The poems enabled holistic re/presentation of each participant's experience, retaining a methodological congruence to the theoretical perspective of the study; narrative meaning is contextual (Gee 2005; Bakhtin 2006) and narrative structure is not linear but involves referral to other parts of the narrative to build complex pictures (Gee 2005). Traditional presentational style, using chunks of narrative to support the interpretation of data is congruent with a fragmentary rather than holistic approach to narrative analysis (Lieblich et al 1998). Within this study the participant's experience was represented by the big narrative; the product of the complex intertwining of a number of smaller narratives which were the units of analysis. The meaning of the big narrative, representing the whole experience, was understood to be greater than the sum of its parts. Thus the poems allowed the whole interpreted experience to be distilled further into an accessible re/presentation.

Discourse provides the language resources for people to narrate their experience. The imagery, metaphors and phrases used by participants are part of these resources and used deliberately by them to represent their experiences. Standing (1998: 191) identified the impact that cleaning up the language used by her participants had on their voice, describing this as having *"homogenized the women's voices, making them all sound (or read) the same. I took away their own (and my own) distinctive way of speaking which*

reflects their background and culture.” She goes on to question whether this decision reproduced the hegemonic power of the establishment, in some way maintaining the marginalization of her participants’ voices. In an attempt to prevent this silencing of the participants’ voices, retention of the language style and imagery of the participants was given priority in the development of the poems, as a means of diminishing the researcher’s power.

Such fidelity to the participants’ use of language was also a means of enabling the audience to gain a window into the language of the participant, using this to inform their interpretation of the meaning of the poem (and therefore the participant’s experience).

Similarly, Gee (1990, 1991), Werth (1999) and Shotter (1993) all acknowledge the role of the narrator in guiding the listener’s interpretation through narrative structure. The narrator’s use of cohesive devices, rhetorical devices, grouping together of ideas in lines stanzas and strophes, language and grammar make some interpretations more rational than others (Gee 1990; Shotter 1993). The retention and repetition of key phrases within the poems brings these narrative elements to the reader’s attention; just as their presence in the original narratives was intended to catch the listener’s attention.

Finally, the poems allow individual, rather than the collective voice, to be heard. They make visible some of the complexities of that individual experience and meaning making activity that participants undertook. In so doing, they are a reminder to nurses that people experience the same events and settings differently, bringing a different set of

expectations, beliefs, values and experiences to the interpretive process. Thus, poetic re/presentation enables research into patient experience to provide an individual perspective, where often it is the common experience that forms the basis of thematic presentation.

IMPLICATIONS FOR PRACTICE

Allred (1998) identifies the authority given to a text warranted by its basis within empirical research, providing the basis for intervention. Choices about presentation of research findings are therefore pivotal to the impact that those findings might have on practice.

Through re/presenting the findings of the study in poetic form audiences – policy makers, health and social care professionals – are invited to engage with the participants' experiences in a way that differs from presentation in the usual academic reporting style. Poetic re/presentation of findings is not denotative, but invites the reader to engage and interpret them from within their own experience and frame of reference. Such interpretive activity has the potential to engage nurses with the experience of patient groups, sensitizing them to the issues that they might experience. This in turn has the potential to influence patient care due to increased understanding.

CONCLUSION

For the presentation of research findings to facilitate the hearing of participants' voices within the dominant discourses of health and academia, it is not only desirable to

decentre the authority of the researcher, but to re/present the participants' experiences in such a way as to encourage the audience to engage with them; artistic forms of re/presentation offer that opportunity to researchers.

LIMITATIONS

Recruitment of the participants through the nursing staff will have influenced access to potential participants and therefore the range of experiences. This was a small qualitative study using a small sample in a particular historical and social context. The findings therefore represent a snapshot of the experience of being a patient on an acute psychiatric inpatient ward. They are not meant to represent a generalisable truth, rather they are meant to sensitise the reader to the issues experienced by the research participants.

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